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ABSTRACT

Mexican Americans differ from Anglo Americans in their types of health problems, relation to the American health care system, and responses to health care. Mexican Americans tend to underutilize available health resources because of fear of discrimination, perception of health workers as government representatives, and language and cultural factors. A relationship clearly exists between the health of Mexican Americans and certain demographic features: low income, little schooling, and ethnic segregation. Studies of mortality rates suggest that Mexican Americans share higher rates of poverty-related health problems with Blacks: rheumatic fever, pneumonia, influenza, and infant mortality. The Mexican American community provides its members with natural support systems: the extended family, folk healers, and religious institutions. Use of medical services is influenced by the cultural value placed on stoic endurance of bad health, and by folk theories of disease, folk remedies, and folk curers. Folk tradition attributes diseases to four causes: "hot and cold" imbalance in the diet, dislocation of internal organs, magical sources, and emotional states. Among Mexican Americans, illness is more likely to be attributed to social or environmental causes than to individual responsibility. Since Mexican Americans perceive the curer's role to be that of kind and understanding adviser, rather than efficient, clinical authoritarian, professional health/social workers should learn more about Mexican American culture to encourage use of social and health services. (MH)

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THE MEXICAN-AMERICAN IN THE HEALTH CARE SYSTEM

by

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ABSTRACT

THE MEXICAN-AMERICAN IN THE HEALTH CARE SYSTEM

by

Moses Stambler

The Mexican-American population differs from the general Anglo-Saxon population. It relates to the American health care system in a manner reflecting its special ethnic and cultural heritage. There are natural supports in the Mexican-American community which help them cope with the Anglo-American health system. This ethnic group has special types of health problems and their cultural background helps them shape their special responses to health care as a sub-group in the Anglo dominated system.

THE MEXICAN-AMERICAN IN THE HEALTH CARE SYSTEM

THE MEXICAN AMERICAN GROUP

The Hispanic group in America is a diversified ethnic group in culture, tradition, practices and perceptions. Included in this group are Mexican-Americans, Puerto Rican-Americans and Cuban-Americans. They are united by the Spanish language, Latin cultural traditions and to a great extent by the Catholic religion.

Hispanics are the fastest growing ethnic group in the U.S.A. (Social Work, 16).

> The rate of immigration of Hispanics from Mexico and Central and South America between 1971 and 1977 was, on the average, 2.6 times higher per year than it was during the 1950s. In addition, it is estimated that from 1971 to 1977, 2-12 million Hispanics entered this country illegally.

Most Puerto Ricans are in the Urban Northeast, Cubans in Florida, and Mexican Americans in the Southwest, a profile of Mexican-Americans indicates that (Ramirez, 3-5),

> As of March 1979, over 1.5 million families were headed by persons of Mexican origin. This number is about 65 percent larger than the number of Mexican-origin families reported by the 1970 census... The size of Chicano families, as measured by the number of persons per family is just over 4 persons per family. Chicano family size has consistently

> remained at least 25 percent greater than non-Chicano family size.... relatively large families remain a significant phenomenon for Chicanos is demonstrated by the proportion of large families defined as those with 6 or more persons. About 21 percent of all Chicano families are this large, in contrast to 13 percent for Puerto Rican families, 17 percent for Blacks, and only 8 percent for Whites... compared to other populations in the United States, Chicano families are larger, have younger family heads, and more minor children and other relatives in the home than all other racial ethnic groups, and they are significantly less likely to be female-headed than are Black or Puerto Rican families.

4. INCOME AND EDUCATION

Education also is an area of significant difference. In the U.S.A., it is heralded as a major route out of poverty yet for Hispanic minority groups, high school dropouts reflect a language blockage of this route (Social Work, 19).

> The dropout rate is so high that masses of youths are illiterate and, therefore, are unable to obtain skilled jobs. For example, Hispanic youths in California drop out of school at a higher rate than do black or white youths. Moreover, less than 5 percent of the Hispanic youths who finish high school are eligible to attend the University of California, compared to 15-17 percent of the

> white youths. The basic problem for Hispanic high-school graduates is not a lack of academic ability but a lack of proficiency in English. The traditional instruments of measuring proficiency, such as the Scholastic Aptitude Test, have shown a continued decline in scores.

Hispanic college enrollment, compared to that of whites, is in lower state institutions. In the colleges, in 1977, 12% of Hispanics aged 18-35 were enrolled in college (17% white, 16% Black), but 45% of those Hispanics enrolled full time were enrolled in lower status Community Colleges (Whites, 26%). Two year colleges are generally terminal experiences for Hispanics (Social Work, 20).

Income differences are also significant. "In 1980, the nation-wide median family income was $21,904 for whites, $14,717 for Hispanics, and $12,674 for blacks." (Social Work, 19)

In addition to lower income, the jobs held by Mexican-Americans also are of lower status (Schreiber, 270).

> The occupations of Mexican-Americans are slowly becoming more diversified but are still most frequently of low prestige. The 1975 population study conducted by the U.S. Bureau of the Census found that more than 60 percent of the occupations held by men of Mexican origin 16 years of age and older were blue-collar jobs.

> In comparison, however, only about 45 percent of all employed men in the United States 16 years and older were classified as blue-collar workers. There were half as many white-collar workers among employed males of Mexican origin than among the rest of the American male population. Overall, males of Mexican origin are employed in less prestigious occupations when their occupations are compared to jobs held by all men in the United States in 1975.

The 1975 figures show Mexican Americans to have completed less years of schooling and to be in lower income groups than the total U.S. population. (See Table 1)

TABLE 1

Percentage of the total U.S. population and of persons of Mexican origin that completed less than 5 years of school and percentage that completed 4 years of high school or more (March 1975).

Years of school completed and age (years)	Total population (%)	Persons of Mexican origin (%)
Persons who completed less than 5 years of school		
25–29	1.0	9.8
30–34	1.0	11.8
35–44	1.9	22.1
45–54	2.5	30.2
55–64	3.5	35.7
65+	11.0	63.8
Total 25+	3.3	24.6
Persons who completed 4 years of high school or more		
25–29	83.2	46.1
30–34	78.6	42.3
35–44	71.5	32.2
45–54	63.8	24.6
55–64	51.9	15.4
65+	35.2	3.6
Total 25+	62.6	31.0

Source: U.S. Department of Commerce (1976:6).

Table 5.4 Income in 1974 of all U.S. families and of families with head of Mexican origin (March 1975).

Family income	Total families (%)	Mexican origin (%)
Less than $4,000	9.0	15.0
$4,000–$6,999	13.0	19.2
$7,000–$9,999	13.9	18.8
$10,000–$14,999	24.4	26.6
$15,000+	39.7	20.4
Total number of families (thousands)	55,712	1,429
Median income	$12,836	$9,498

Source: U.S. Department of Commerce (1976:7).

Source: Schreiber, p. 271

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Compared to other ethnic groups in America, Mexican Americans rank quite low in employment and educational status.

TABLE 2

RANK ORDER OF ETHNIC GROUPS AND RACES IN THE UNITED STATES, 1950 AND 1970, ACCORDING TO SELECTED CRITERIA

Group	White Collar Employment		Professional and Managerial Employment		High School Education		College Education		Average or Overall Rank	
	1950	1970	1950	1970	1950	1970	1950	1970	1950	1970
Russian*	1	1	1	1	2	2	1	2	1.25	1.40
Chinese	4	4	2	2	7	4	2	1	3.75	2.80
British	2	2	3	3	3	3	3	4	2.75	3.40
Japanese	10	6	10	6	1	1	4	3	6.25	3.60
Irish	3	3	5	5	6	6	6	6	5.00	5.20
Swedish	5	5	4	4	4	7	7	7	5.00	6.33
Polish	8	9	8	9	9	9	9	8	8.50	7.60
German	7	7	6	7	8	8	8	9	7.25	7.80
Italian	9	10	9	10	10	10	10	10	9.50	9.80
American Indian	14	12	14	11	13	11	13	12	13.50	11.60
Mexican	12	11	12	12	14	13	13	13	12.75	12.00
Afro-American	13	14	13	13	12	12	12	11	12.50	12.60
Puerto Rican	11	13	11	14	11	14	11	14	11.00	13.80

SOURCE: Richard M. Burkey, *Ethnic and Racial Groups* (Menlo Park, Calif.: Cumfungs Publishing Co., 1978), p. 339.
* Predominantly Russian Jews.

Source: Social Work, 8

A relationship clearly exists between the health of Mexican Americans and the above demographic features, low income, little schooling, and ethnic segregation. Health is impacted (Schreiber, 272),

> (1) by increasing exposure to infectious diseases through crowded housing and lack of treated drinking water or sewerage; (2) by decreasing awareness of preventive measures in disease control (for example, as a result of not being able to read a health bulletin or to understand germ theory); (3) by restricting access to health care because of an inability to pay for physicians' fees, medicine, and special treatment; (4) by barring a person from health-care services through ethnic discrimination; and (5) by increasing the chances of inappropriately using the less costly types of health care (for example, lay curers or midwives).

5. HEALTH

There is a shared experience of Mexican-Americans in regard to their social and psychological bonding in the face of an Anglo oriented medical system (Harwood, 1).

> People who have been raised in an ethnic collectivity-that is, a group with common origins, a sense of identity, and shared standards for behavior - often acquire from that experience not only basic concepts and attitudes toward health and illness but also fundamental styles of interpersonal behavior and concerns about the world. The effects of this enculturation carry over into health-care situations and also become an important influence on personal activities devoted to health maintenance and disease

> prevention. Ethnic differences are therefore of practical concern in treatment situations when patients and providers of care come from different ethnic backgrounds - that is, when the providers are likely to be unaware of the culturally derived expectations and views of their patients. In such circumstances, health personnel may be unable to respond appropriately to the personal needs of patients for information, reassurance, and effective treatment.

There is generally an underutilization of available health resources by Mexican-Americans, suggesting the need to bring these services out to the community, an outreach approach.

Three factors contributed to this underutilization of health services in a study by Watkins (Watkins, 68):

> (1) Mexican Americans tended to view the public health worker as a representative of the government and therefore as a potential threat (2) such workers were usually Anglo, which reactivated long-standing group tensions between Anglos and Mexican Americans, and (3) Mexican Americans feared discrimination in treatment and showed a high sensitivity to criticism from Anglo health personnel.

Mexican Americans also underutilize mental health services, probably because of language and cultural factors (Watkins, 68). (See also Gavirio, 65 for a general discussion of this topic)

> ... the underutilization of mental health services is significantly affected by language differences, and they theorized that Mexican Americans frequently use the family physician as a mental health practitioner because they tend to perceive a unity in mental and physical problems. Other factors credited ... as having a strong influence on Mexican Americans' hesitancy to use mental health services include this population's often demeaning contacts with mental health agencies and the lack of mental health facilities in the Mexican American community... (There are) three variables in Mexican Americans' underutilization of mental health facilities: the inaccessibility of such services to barrio residents; the language difference between Spanish-speaking clients and English-speaking therapists, which presents serious obstacles to communication; and differences in the class-bound values of clients and agency staff.

B. NATURAL SUPPORT SYSTEMS IN THE MEXICAN-AMERICAN COMMUNITY

1. COMMUNITY

There are a natural support systems in their community to which Mexican-Americans turn for important emotional and physical assistance. These are the extended family; the folk healers and religious institutions. The extended family is one important support and is activated at various life stages (Delgado, 84).

> Chicano families... use the ritual kinship process known as "compadrazgo," which formally includes friends and key neighbors as well as distant relatives in the immediate family constellation. The compadrazgo ritual kindship process serves to "widen and enhance the individual's primary

> group by either transforming outsiders into family members or more distant relatives into particularly close associates. ... This ritual kindship process is achieved through an individual's formal participation in any one of four ceremonies: (1) baptism, (2) first communion, (3) confirmation, or (4) marriage. The first three types of ceremonies require members (usually a married couple) to assume the roles of compadre (godfather) and comadre (godmother). The child's compadre and comadre assume responsibility for the child's welfare should tragedy befall the natural parents. In essence, the compadre and comadre become parental substitutes and often assume an active role in the rearing of the child. Also, as in other non-Hispanic cultures, marriage develops reciprocal formal obligations between two families. Thus, family resources can be mobilized during crises.

2. THE FOLK HEALERS: CURANDERO-CURAIDERA (Female)

The folk healer (Curandero) plays the primary and valuable role in the Mexican-American health support system by helping to maintain a balance between the physical and mental spheres. The practice of (Delgado, 85),

> Curanderismo is based on the premise that illness and bad luck are brought about by weakening ties with the Roman Catholic Church, the family, and the culture. ... religion represents a central focus of curanderos in Mexican American subcultures. The theme of Christ permeates much of the curandero's thinking about illness and misfortune. Curanderos see their work as harmonious with orthodox religion and do not view themselves to be in conflict with Catholicism. The curandero's mission, like his or her counterpart in other Hispanic groups, is to use culturally symbolic techniques to return individuals to harmony with the culture and God.

3. HERBALIST

The herbalist focuses on naturalistic medicine and maintaining the equilibrium of health through a balance of both temperature and moisture in the body. In the balance focus of this "hot and cold" belief system (Delgado, 85),

> Certain diseases, herbs, foods, and medicines are classified as having "hot" or "cold" origins and properties. Once a disease has been categorized as either "hot" or "cold," medication is prescribed to reestablish the individual's equilibrium. "Hot" illnesses require "cold" remedies, and vice versa. For example, arthritis and respiratory infections are two common "cold" illnesses that need to be treated by "hot" substances such as tea, alcohol, garlic, or onions, to list four possible choices. "Hot" illnesses cause the patient to experience an increase in temperature, either real or imaginary, and can take the form of diarrhea, rashes, constipation, or ulcers, to name a few. Treatment requires "cold" foods or substances such as fruits, baths, or vegetables. An herbalist will develop a treatment plan that may include a combination of foods, baths, or teas.

On the basis of cultural preferences, it is clear that services to the Mexican American Community should take into account the support services already inherent in the natural support system (Delgado, 87).

> ... some needs, such as medical care and pharmaceutical products or emotional support for interpersonal problems, may be the same as those in mainstream American culture, (but) Hispanics may want these needs addressed in culture-specific ways.

> Thus, even in a large city such as Boston, certain characteristics of the support systems have a quality of a smaller community: personal relationships with healers or clergy, the use of herbal or home remedies reminiscent of rural settings, and the patronizing of small, community-based, non-bureaucratic establishments.

WHY DOES FOLK-MEDICINE PERSIST IN A SCIENTIFIC SOCIETY

Folk medicine has a vital function of helping restore the social equilibrium.especially for a group with defined lower status. It is a pervasive and positive influence,and .(Clark, 203)

> ...a functional part of the people's way of life,
> ...a dramatic means of "acting out" social disturbances resulting in anger, fear, shame, or anxiety. Through disease an individual can demonstrate vividly to others that "something is wrong" with his social environment and that he needs the assurance and support of family, friends, or community. These disorders, furnish the group a rationale for making social advantageous adjustments.

4. FAMILY

As with families in general, Chicano family roles are shaped or determined by a wide range of variables, many of which may have little to do with culture per se. There is internal diversity among Chicano family types, due to such variables as region, recentness of migration to the United States, education, social class, age, and urban-rural locale. Yet, despite these different variables, there is a basic similarity in Chicano family support structure, that differentiates them from the dominant "Anglo" norm (Ramirez, 24).

> ... Chicanos and Anglos have substantially different local kinship structures. Chicanos have local kin in more households and the families in these households are more fully integrated and are more likely to encompass several generations... changes in conjugal role structure do not require a decline in level of ethnicity, i.e., Chicano families can be modern and ethnic at the same time.

The Chicano family is unlike the European but does not represent an adjustment to industrial society as much as an extension of the Mexican family tradition (Ramirez, 10-11).

> The classical European extended family model is the trigenerational household of children, parents, and grandparents in an interdependent environment. (The Chicano) casa-familia model makes a sharp and important distinction between the household (casa) and the kinship network (familia)... the Aztec calpulli (is viewed as a) possible antecedent of the Mexican-American extended family... The Chicano family represents a special case of modified extended or kin-integrated family, and that the form and structure of the Chicano extended family did not develop within American industrial society, but rather transferred from Mexico.

There is a different spatial and emotional attachment to families in Anglo and Mexican culture groups (Ramirez, 13).

> Anglos who do not have relatives in town go to friends for help more often than those Anglos who do have relatives nearby, and that those with kin in town rely on relatives more than those who lack nearby kin.

> This contrasts with the Mexican-Americans who consult most often with relatives whether or not they have relatives living in town: Thus, Mexican Americans consistently rely on relatives most often for emotional support regardless of their geographic accessibility, while Anglos turn to friends more often than to relatives when kin are inaccessible and equally as often when kin are present... Anglos lack a preference for familial emotional support.

How does distance from their native Mexico impact the Chicano family structure (Ramirez, 15).

> ...as Chicanos become farther and farther removed generationally from Mexico, they lose significant awareness of and contact with their cultural heritage, while at the same time enhancing their awareness of mainstream American culture. Yet familism, both in terms of values and behaviors, is at "the core of a culture" and is thus retained and maintained, while more superficial cultural traits are discarded and forgotten by succeeding generations. In short, the Chicano extended family does not necessarily decline with decreasing cultural awareness and loyalty.

In the kinship relations, there are two levels of kin relations these are: "primary kin" (parents, siblings, adult children of spouse) and "secondary kin" (aunts, uncles, grandparents, cousins, nieces and nephews). These kindgroup get involved in two types of interactional exchange which helps define both the level and quality of family interaction (Ramirez, 16).

> ...basic exchange, including financial gifts or loans and the provision of shelter, and personal service exchange, including labor; baby sitting, sickbed care, and personal advice with problems and transportation... Basic exchange was carried on almost exclusively with primary kin, while personal service exchange was carried on almost exclusively with secondary kin.

The major support systems for Mexican-Americans family, folkhealers and religious institutions serve to meet important psycho-social needs of that community (See Table 3)

TABLE 3

BREAKDOWN OF NEEDS SERVED BY NATURAL SUPPORT SYSTEMS IN HISPANIC COMMUNITIES

Needs Served	Natural Support Systems		
	Extended Family	Folk Healers	Religious Institutions
1. Accessibility to community	X	X	X
2. Communication in Spanish	X	X	X
3. Continuation of cultural traditions	X	X	X
4. Crisis intervention	X	X	X
5. Emotional support for interpersonal problems	X	X	X
6. Friendship, companionship, trust	X	X	X
7. Identification with Hispanic role models, leaders, or experts	X	X	X
8. Information and referral	X	X	X
9. Care and treatment of the disabled or aged	X	X	X
10. Financial aid or credit	X		X
11. Medical care and pharmaceutical products	X	X	
12. Recreation	X		X
13. Translation or interpretation	X		X
14. Advocacy	X		X
15. Physical and emotional rehabilitation		X	X
16. Religious or spiritual affiliation		X	X
17. Babysitting, day care, respite care, foster care, or adoption	X		
18. Child rearing and parent education	X		
19. Educational alternative to public school			X
20. Housing	X		

Source: Delgado, 87

C. HEALTH PROBLEMS OF MEXICAN AMERICANS

1. EPIDEMOLOGY

. Mexican Americans are lumped together with other whites in official records making it difficult to compare their mortality and morbidity rates with those of other groups. However, studies of mortality rates that use the Spanish surname as a category, suggest that Mexican Americans share poverty-related health problems that are the main cause of poor health among blacks. People with Spanish surnames are much more likely to die of rheumatic fever, pneumonia, and influenza than are members of the Anglo population. These death rates are clearly related to a lack of adequate medical care for early treatment and/or use of antibiotics (Bullough, 77).

Neonatal deaths were three times as high among the Spanish-surname group as among Anglos (in Colorado), reflecting not only less adequate conditions at and following delivery but also a lack of prenatal care, and the poor general nutrition and health of the mother.

Mexican Americans are much less likely to die of neoplasms, vascular diseases, and heart disease than other Americans, because many don't live long enough to acquire these diseases associated with aging, nor do they participate in affluent lifestyles associated with these diseases (Bullough, 78).

2. LANGUAGE BARRIER IN HEALTH SCIENCES

Monolithic Spanish language speakers are at an evident disadvantage in securing adequate health services. In Los Angeles (a major center for the Mexican American population), hospitals have minimal Spanish speaking aids or interpreters (Bullough, 79). Some hospitals (e.g. New Britain General in Conn.) have introduced bi-lingual social workers as an outreach measure.

D. CULTURAL TRADITION AS A SHAPER OF RESPONSES TO HEALTH SERVICES

1. TRADITIONAL ATTITUDES

The Mexican tradition is an important screening device for Mexican-American perception and use of medical services in hospitals (Bullough, 79-80).

> One of the difficulties is a cultural tradition that suggests that bad health, though unpleasant, is something that one endures. Men of the barrio tend to be particularly spartan in their attitude toward illness, and there is a belief that a man who admits to illness is not macho (i.e., tough and rugged). Sickliness somehow reflects moral and physical weakness. Often, a person who is ill is commended by friends and relatives for endurance. For example, a man with a high fever and accompanying pain who continues to work is admired because of his continued willingness to work. Women and children are allowed to show more weakness during illness than men. Some of this traditional acculturation is strengthened by the strains of wage earning in the United States, since a man unable to work is a man unable to support his family. For women who work outside the family, much of the same stoicism about pain is demonstrated. Also complicating treatment is the traditional Mexican preoccupation with privacy, a preoccupation that demonstrates itself in the health setting in over-pronounced modesty. Natural functions such as urinating, defecating, and bathing are considered one's private activities, not observed by others.

2. OTHER SHAPERS

Receptivity to health services also is shaped by economics, social class, and degree of Americanization (Bullough, 83).

> The primary source of medical care in most Mexican villages and in the poorer sections of the cities is the folk medical practitioners whose knowledge is based upon an elaborate and well-developed system of beliefs acquired outside of any regular educational institution. Though upper-middle-class Mexican Americans, as well as the more Americanized person in the lower-income groups, have abandoned much of the folk medical practices, the newly arrived and the poor of the barrios usually favor the folk system over American scientific medicine. Often, they divide diseases into two categories, consulting a folk practitioner for the traditional diseases but an Anglo physician for "Anglo diseases." (Most know about and use) ... the folk system of diagnosis and therapy for at least part of their care.

There are a number of therapeutic practices which are derived from Mexican patterns and based on various "folk theories" of disease. These folk cures can be administered by anyone who has the required knowledge of herbs and other folk cures including self of relatives and friends. One may also seek out the services of a Curandero, a specialist in the diagnosis and treatment of Mexican based folk-illnesses (Clark, 163).

> Folk therapy consists of oral administration of various herbs and purgatives; topical application of liniments, oils, and herbal mixtures; massage (sobadas); "cupping" (ventosas); regulation of the diet; and magical cures. Any one or a combination of these may be used for a particular syndrome.

3. CURANDERO

The major folk practitioner in the Mexican-American community is the curandero (curandera, in the case of a woman) (Bullough, 83).

> This person not only has acquired considerable empirical knowledge but also possesses the charismatic qualities associated with the more spiritual aspects of the role. A good curandero shows great warmth and concern for both the patient and his family. He offers advice, gives treatment, but asks for no fee. Special prayers are often a part of his therapy. If the treatment proves successful, the family is expected to give him an offering, but if he fails nothing is expected. This means that, because no fee will be forthcoming, the curandero will often refuse to treat a patient who from previous experience he knows he cannot cure or who he thinks has a bad prognosis. In these cases, the family turns to the Anglo physician or hospital. The implication of this is not lost upon the patient who tends to associate hospitalization and the American physician with a fear of death or serious disability, otherwise he could have been cured by the curandero.
> The curandero is not the only folk practitioner; usually, before he is sought out, home remedies will have been tried and a neighborhood senora (older woman) will have been consulted.

E. THEORY OF DISEASE

Theories of disease for the Mexican-American are derived both from Mexican folk-belief and from the world of scientific medicine recognized both in the U.S. and Mexico (Clark, 164).

> Diseases of "hot and cold" imbalance, diseases of dislocation of internal organs, diseases of magical origin, diseases of emotional origin, other folk-defined diseases, and "standard scientific" diseases.

Diseases in this tradition fit into four categories and are treated on this basis. These are (1) diseases of hot and cold imbalance, (2) dislocations of internal organs, (3) illnesses of magical origin, and (4) illnesses of emotional origin (Bullough, 84).

1. HOT AND COLD IMBALANCE

> Illness is thought to be caused by a disequilibrium that can be the result of a dietary imbalance or exposure. Usually, a dietary regimen or herbs is prescribed to cure the imbalance. Whether a food used in this treatment is classified as hot or cold is not necessarily related to its actual temperature; for example, ice is considered hot because it burns the mouth. That such foods as chili peppers and onion are classified as hot seems quite logical, but the classification of tomatoes, citrus fruits, cucumbers, and chicken as cold is less apparent to the outsider, and the fact that white beans are considered hot while red beans are cold carries no clue to the uninitiated. It is apparent that the curandero must absorb a large body of knowledge in order to master the whole system. Because of the complexity of the system, the average individual usually does not know all of the classifications, and turns to the curandero for advice. Symptoms of imbalance include head colds, stomach upsets, and general malaise. Infants are thought to be particularly susceptible to "cold stomach," which means that dedicated believers in this system do not give cold foods, including citrus fruits, to their infants, in spite of the exhortations of public health nurses. Expectant mothers are often cautious about eating too many foods that are classified as hot, because it is believe this will cause their babies to have diaper rashes when they are born.

A partial classification of "hot" and "cold" foods is indicated in Table 3.

TABLE 3

HOT AND COLD FOODS

Food Types	Very hot	Hot	Temperate	Cold	Very cold
Vegetables	Chile pepper, green Chile pepper, red Garlic	Onion		Beans, green Beets Cabbage Carrots Cauliflower Coriander Parsley Peas Pumpkin Radish Squash Turnip	Cucumber Pickles Purslain Spinach Tomato
Meats and milk	Crackles	Capon Fish Milk, goat's Pork Turkey	Goat	Beef Boar Lamb Milk, cow's Milk, donkey's Mutton Rabbit	Hen or pullet Milk, human
Starches and sweets	Beans, white	Barley Bread, wheat Beans (*habas*) Chick peas Potato, Irish Potato, sweet Rice Sweet rolls Tortillas, wheat Wheat Honey Sugar, brown Salt	Beans, pinto Sugar, white	Beans red Lentils Oatmeal Tortillas, corn Vermicelli	

In addition to the above classifications of foods, a wide variety of herbs also are used to redress the hot and cold imbalance (Clark, 167).

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2. DISLOCATION OF INTERNAL ORGANS - (Bullough, 85)

The second category for Mexican diseases is that of Internal Organ dislocation.

> Mollera ciada, or fallen fontanel, is the most common type of organ displacement. It is usually attributed to a too-sudden withdrawal of the nipple from the infant's mouth. Symptoms of the ailment include diarrhea and vomiting. In folk medicine the cause and effect are often reversed from that of scientific medicine. The fact that mollera ciada is such a well-known ailment is evidence that severe diarrhea is still common among infants in the Mexican-American community and still a leading cause of the high infant mortality rate.
>
> A less common ailment attributed to a misplaced organ is that of infertility, which is sometimes explained as being due to a fallen uterus. Barrenness is a cause of great sadness, because marriage and family are such important aspects of the culture and women who are mothers are the most highly respected. Barrenness is also regarded as a threat to the male, since a man is measured by his machismo, or manliness, including the ability to produce children. The curandero may attempt to treat the infertility with religious and magical cures and massage.

3. DISEASES OF MAGICAL ORIGIN (Clark, 174)

A third category of diseases are those caused by purely magical sources. These include Mal Ojo, the evil eye, which can be cured with eggs, and Mal Aire, bad air, in which evil spirits in the air possess on unsuspecting victim (Bullough, 86).

> The unsophisticated Mexican-American mother may believe that, when someone, particularly a woman, admires her infant but fails to touch him, the baby will develop symptoms of mal ojo, including fitful crying, wakefulness, diarrhea, vomiting, and fever. If the person who admires the child touches him, the spell will be broken and no illness occurs. Unfortunately, social workers and nurses are sometimes blamed for casting the spell because they unwittingly admire infants in this manner. Once the symptoms of mal ojo develop in either a child or an adult, the victim can be treated only by magical means.
>
> Mal aire (bad air) as a cause of illness is not so well known throughout the world as the evil eye, although many peoples believe in vague types of airborne spirits that cause illness. Symptoms of mal aire can include facial paralysis, convulsions, or other frightening symptoms. The curandero may treat the disease with massage and counter-spells.

4. DISEASES OF EMOTIONAL ORIGIN

Another origin of disease recognized in Latin America and by the Mexican-American Community are the prolonged or intense emotional states. These include Susto or Esperatio (fright and loss of soul) and Bilis (anger, upset or nervousness), and these can be treated with the appropriate herbs and magical remedies. (Bullough, 87)

> Susto is believed to occur most often in children, although no age is immune, because susto seems to be broadly defined to include much more than what we would call fright: almost any traumatic emotional illness can be the cause of susto. Ritual prayers are a common treatment of susto, sometimes combined with the use of herbal remedies. In such cases, the curandero may also try to manipulate the physical and psychological environment of the patient in order to lessen the emotional stress, although the patient undoubtedly would not explain his or her actions in these terms.

Bilis however is a disease more often confined to adults. "It is manifested by nervousness, emotional upset, and the physiological symptoms of the type psychologists and psychiatrists generally link with anxiety; Herbs and emotional support are used to treat it " (Bullough, 86).

F. SOCIAL FUNCTION OF ILLNESS

1. FUNCTIONS

There are a number of social functions that illness serves in the Mexican-American Barrio community (Clark, 198).

> Illness may serve to publicize and punish social offenses. When someone gets sick, his ailment may be interpreted by the community as the natural result of conflict with another member of his social group, and focus attention on the person or persons who have "mistreated" him.

Illness may also "... provide escape from social disapproval by affording a rationale for otherwise unsanctioned behavior," and provide a socially acceptable way out of culturally prescribed obligations (Clark, 199).

Illness also can be used as a cultural defense against the perception of oppression by Anglo-society. As "... a means of dramatizing to others the evil consequences of cultural change and of defending the "old ways" - Mexican customs and traditions which are under constant attack in the United States " (Clark, 201). Attributing disease to the demands of Anglo society or to the ways of American life which are uncongenial to the patient, are some of the ways this can be done.

2. INDIVIDUAL AND CULTURAL REACTION TO ILLNESS

How do Mexican Americans react to illness? They do not like to admit illness because their associates may think them weak or lacking in stamina (Clark, 198).

> They try to "be strong" and often refuse to accept the fact that they are sick until they become acutely ill. Once the idea of illness has been accepted, however, a patient rarely thinks of blaming himself for the disorder. He has done what he could to withstand disease. He is not responsible for getting sick; illness just happens to people.

The sick role is culturally prescribed and defined (Clark, 195).

> In addition to the actual physical pain and suffering involved, "being sick" deprives the patient of certain social privileges which he would otherwise enjoy. Barrio people sometimes fear that if they become ill their family and friends will somehow lose respect for them. (Mexican Americans)... do not readily succumb to illness. Life as they see it is full of countless pains and traumas. Hunger, grief, cold, fear, pain - these things are all a part of life and should be borne with courage and dignity... They (make) an effort to continue regular activities and duties as long as possible. ... giving in to illness with the first appearance of symptoms (is) an admission of weakness or lack of stamina... Men of the barrio tend to be particularly spartan in their attitudes toward illness. A man who admits to illness is not macho (tough and rugged). He feels, as do many Anglos, that sickliness reflects moral weakness.

3. WHO IS TO BLAME FOR ILLNESS?

BLAMING THE VICTIM OR BLAMING THE SOCIAL ENVIRONMENT

In Anglo society, we have focused on the individual rather than the social environment as the causative factor of disease. This helps reduce pressure for environmental control by placing responsibility and blame on the victim (Clark, 196-7).

> In Anglo groups one often hears these remarks: "I got sick because I didn't take care of myself"; I'm sorry that I got sick." These ideas, common in the lives of many Americans, reflect a sense of guilt on the part of the sick person. He is often apologetic for an illness, perhaps because others- his family, his friends, or his doctor- remind him that he neglected to take steps to avoid disease: "Why didn't you take care of yourself?"

> With a wider public awareness of contagion, preventive medicine, and hygiene, there is a tendency to place blame for illness on a patient or those responsible for his welfare. In some segments of Anglo society a patient (or his parents if the patient is a sick child) is expected to accept the responsibility for disease and somehow to atone for his misdemeanor by feeling guilty, by accepting even vitriolic criticism, by offering apologies, and by promising to "repent and sin no more."

The Mexican American Community is more likely to treat the social causes of illness. In the Mexican American Barrio (Clark, 197),

> ...the patient is regarded as a passive and innocent victim of malevolent forces in his environment. These forces may be witches, evil spirits, the consequences of poverty, or virulent bacteria which invade his body. The scapegoat may be a visiting social worker who unwittingly "cast the evil eye." It may be a member of the sick man's social group who "made him sick" by frightening him, making him angry, or otherwise upsetting him emotionally. Blame may be projected to the demands of life in urban America.
>
> Mexican folk concepts of disease are based in part on the notion that people can be victimized by the careless or malicious behavior of others. Thus illness is sometimes an effective tool of social control.

Clearly, the environmental concept of illness is more readily acceptable in the Mexican-American context, and individual responsibility for illness more acceptable in the Anglo context.

4. ROLE OF THE SOCIAL GROUP IN ILLNESS

What is the role of the social group in an ill situation? The Barrio people (Clark, 203-4),

> do not act as isolated individuals in medical situations. In illness as well as in other aspects of life, they are members of a group of relatives and compadres. Individuals are responsible to their group for their behavior and dependent on them for support and social sanction. Medical care involves expenditure of time and energy by the patient's relatives and friends. Money for doctors and medicines comes from the common family purse; many of a sick person's duties are performed during the period of illness by other members of his social groups. Illness is not merely a biological disorder of the individual organism - it is a social crisis and period of readjustment for an entire group of people.
>
> It is customary, therefore, for an individual to present his symptoms to his relatives and friends for their appraisal before he takes steps to obtain medical treatment.

Because of this social involvement of illness, social validation is required before the ill role may be taken (Clark, 205).

> ... an individual is not socially defined as a sick person until his claim is "validated" by his associates. Only when relatives and friends accept his condition as an illness can he claim exemption from the performance of his normal daily tasks.
>
> In relations with medical personnel, then, a patient is not free to make immediate and conclusive decisions concerning his own health. He is acting not as an individual but as a family member.

This social validation differs from that of Anglo medicine where the physician is the court of appeal and the required validator before a person may assume a sick role.

The family assumes a vital control function in the illness of one its members (Clark, 206).

> The pattern of reserving for the group the right to control the medical treatment of its members is sometimes in conflict with the expectations of Anglo health personnel. In the society to which most American doctors and nurses belong, the concept of individual responsibility and self-determination is a well-developed pattern in (the Barrio) it is almost nonexistent. When a Spanish-speaking person is asked to make an on-the-spot medical decision on his own initiative, he is placed in an embarrassing, impossible situation.

The definition of good medical care in the Mexican American Barrio has a strong family and social base (Clark, 206).

> It requires that the patient be treated for almost any condition at home by relatives and friends, who are constantly in attendance and who provide emotional support as well as the technical skills required in treatment. In time of sickness one expects his family to surround and support him, and to supervise closely and critically, if not actually carry on, the treatment process. Members of the family, in turn, feel obligated to remain close to the patient, to take charge of his treatment, and to reassure him as to his place in and importance to the family group.

It is evident that the family institution serves a vital role in the Mexican-American's social environment of health.

5. ROLE OF THE MEDICAL AUTHORITY OR CURER; AREAS OF CONTRAST WITH ANGLO HEALTH

Mexican-American differences from the Anglo health system are reflected in its different approaches to (1) authority of the physician, (2) the objective approach, and (3) the concept of "efficiency " (Clark, 213).

> In the United States the social role of the "scientific" curer demands that he accept responsibility for the patient's recovery and that he be allowed to meet this responsibility by assuming a great deal of control over the patient's actions. A doctor usually expects that the prestige of his training will cause laymen to accept his judgment and to follow his advice. As a highly trained and skilled technician, he expects recognition as the final authority in medical matters.

For the Mexican-American, it is the family that is the authority and whose primary role in health is clearly defined by tradition (Clark, 213).

> ... the curer's role in Mexican-American culture is not an authoritarian one. Curers may advise, but they may not dictate. Medical advice may be followed only if it is sanctioned by the powerful members of the patient's social group. Anglo patients, who are accustomed to looking to the "family doctor" for sage advice in many departments of life, may follow "doctors' orders" to change jobs, move to a different neighborhood, abstain from sexual activity, enroll junior in military school, or learn to play golf.

> The role of the curer, for Spanish-speaking people, is much more restricted - his job is to consult and advise in medical matters. He may diagnose disease and administer appropriate medications only if the patient and his family believe that his prescriptions are necessary and appropriate. Barrio people regard the "nonmedical" aspects of life - employment, residence, sexual contacts, child rearing, and recreation - as lying completely outside the doctor's province. To them the physician is not a final authority.

In the U.S. medical authority is expected to provide an objective approach, with minimal emotional involvement with the patient (Clark, 215).

> ... medical training in the United States teaches physicians that scientific accuracy depends on their "affective neutrality." Doctors must repress subjective reactions to their patients, must refrain from interacting emotionally with them, and must remain "clinical" in their attitudes. It is of some interest that the term "clinical" in modern English usage has come to connote a lack of emotion, a coldly impersonal approach-the antithesis of warmth and friendliness... Good "bedside manner" is especially important in the treatment of Mexican-American patients. They expect a curer to reassure them, to show that he sympathizes with them and cares what happens to them. They reason that if the curer has no interest in his patients, he may not really try to help them; he must be practicing medicine for only one reason - to make money. If the physician's approach is too "clinical," his attitude may be interpreted as one of hostility. A high fee confirms the patient's belief that the doctor "doesn't care what happens to me as long as he gets his money."

The Mexican Americans require kindness and understanding in their curers rather than efficiency (Clark, 216), and

> ...they are often unprepared for the doctor's hurried examination and abrupt dismissal. One of the more frequent complaints heard from Spanish-speaking people is, "The doctor didn't do anything - he just saw me for a couple of minutes and gave me some pills." Folk curers, on the other hand, usually give a lengthy and impressive performance; they sometimes work with a sick person an hour or more at a time.
>
> Barrio people are not in a great hurry about something as sobering as illness. "Efficiency" is not considered a particularly admirable trait. They much prefer that the physician be calm and cautious, and observe the little social proprieties that Mexican-Americans regard as a sign of courtesy and good will. They usually interpret a doctor's haste as rudeness or discourtesty.

There is a needs of professional health and social workers to consider the Mexican-American patient within the folk-medicine framework (Bullough, 89).

> Closer working relationships with the folk practitioners, knowledge about the culture, and understanding of the individual patient could help the health worker deliver more useful care. Often, the very definitions of health and illness differ between professional and patient. ... there is a widespread belief that, if a man is not emaciated or in pain and can perform his work role adequately, he is well and has no need for medical care. The professional who holds a preventive orientation to illness may value health care for the well person in the form of immunizations and early treatment of illness before it is debilitating.

Such workers would feel less frustrated if they realized that this difference in outlook exists to a certain extent among all poor people, because a preventive health outlook correlates with an ability to control the future, and poverty makes such control impossible. What the professional needs to do is make preventive services seem more reasonable to the patient by integrating them with the acute care that the patient realizes he or she needs. The practitioners would thus demonstrate that they are willing to do their share to bridge the existing gap between the health care professionals and the members of these Spanish-speaking subcultures.

Additional suggestions for social worker activity to reduce or eliminate the feelings or reality of oppression by a Mexican-Americans include (Harwood, 21-25).

1. Dealing with class and professional barriers to the realization of ethnically appropriate health care
2. Eliciting the patient's model of the problem and treating the illness
3. Making medical treatment more comfortable with the patient's lifestyle, and
4. Improving the articulation between mainstream and nonmainstream sources of health care

SUMMARY -

The Mexican-American ethnic group, faces discrimination in American society. Their income and education levels within the demographic realities, as well as their cultural differences, place them at a disadvantage in the Anglo oriented health care system. Their extended family and compadre system provide them with advantages in coping with health needs satisfaction. Their traditional views on the nature and amelioration of illness provide an important ideological and support network for their cultural survival. Social workers should learn more about Mexican-American culture to help facilitate their utilization of social and health services.

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